S. HRG. 98-623, PT. 2

ORGAN TRANSPLANTATION

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

EXAMINATION OF THE PROBLEMS INVOLVED IN OBTAINING ORGANS FOR TRANSPLANT SURGERY

MAY 25, 1984

OKLAHOMA CITY, OKLA.

PART 2

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE

36-135 O WASHINGTON : 1984

S541-59

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ORGAN TRANSPLANTATION

FRIDAY, MAY 25, 1984

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Oklahoma City, OK.

The committee met, pursuant to notice, at 1 p.m., in the auditorium, Presbyterian Hospital, Northeast 13th at Lincoln Boulevard, Oklahoma City, OK, Senator Don Nickles (acting chairman of the committee) presiding.

Present: Senator Nickles.

OPENING STATEMENT OF SENATOR NICKLES

Senator NICKLES. I want to open by welcoming all of you and thanking you for participating in today's hearing on organ transplantation. Our witnesses will be sharing their experiences as patients, doctors, and community leaders in the field of transplantation. Their testimony will shed light on both the gains that have been made in organ retrieval and transplantation and the problems which continue to plague the system.

I would like to state my sincere thanks to Presbyterian Hospital for hosting this hearing. On the medical panel, we will be hearing from Mr. Harry Neer, the administrator of Presbyterian Hospital. Both Mr. Neer and his staff have been most gracious in their assistance to me and my staff in this hearing.

This is an official hearing of the Labor and Human Resources Committee of the U.S. Senate. We do have a transcriber present and all the remarks will be made a part of the record. If you desire a copy of the remarks, you might contact our office.

Like many, the issue of organ transplantation first drew my attention when a number of appeals for organs were made by parents and/or by the President of the United States in the past few years. We are all grateful to the President and to the press for their continuing service in highlighting the various needs for organs. However, all of us know that such an approach to finding organs and saving lives is, at best, a temporary solution. Certainly it is not the most efficient or equitable system.

Because of the problems which these appeals have demonstrated, other Members of Congress and myself introduced legislation to try and facilitate a better matching system between those who need organs and available donors. The bill that we have introduced has four major provisions. First, it establishes a task force within the Department of Health and Human Services to study the existing national network and to develop a plan for further coordinated efforts in organ procurement. Second, it gives authority to the Secre-

tary of HHS to establish and to operate an organ procurement and transplantation registry. This would be contracted out to those organizations in the private sector which already have begun efforts towards this goal. The registry will list potential organ recipients, potential organ donors, and a matching system to link the two.

Third, the legislation would provide grants to organ procurement organizations to assist their efforts in organ retrieval. Finally, the legislation prohibits anyone from seeking to profit through the buying and selling of organs for transplantation.

I am happy to say that this legislation passed the Senate in April of this year. The House of Representatives has their own version of this bill which appears to be headed for passage in the near future. I am confident and very optimistic that it will be passed this year.

Washington cannot solve all the problems which exist in organ procurement and transplantation with this legislation, or any other legislation, for that matter.

Financing many of these expensive transplantations is a problem faced by many people, as we have seen in the case of Terri Lenz of Oklahoma. Terri was required to have, I think, up to $250,000 or $300,000 on hand before the hospital would even put her on the waiting list for a heart and lung transplant. On the average, major organ transplants cost about $200,000. Kidneys are the only organ reimbursed by private or public insurers as a general rule. All others, with the exception of tissue transplants such as corneas, are considered experimental. These are generally not covered by insurance.

Other problems exist, but the main weakness in the current transplant network is a shortage of organs. Financing transplants becomes secondary if there are no organs available for transplants. The waiting list for organs is enormous. For example, there are 7,000 people waiting for kidney transplants today. For livers, there are 130 adults and children waiting. For hearts, there are over 25 persons on the waiting list. For heart or lung, there are over 20 people on the waiting list. In every case, with the exception of kidneys, these patients' lives hang in the balance—dependent upon the life-saving gift of someone else's tragedy. As the waiting list grows and many die for lack of donors, so grows the pressure to find more potential donors.

What are the possibilities of retrieving more organs? The only kind of death which can produce organs suitable for transplants is brain death. Each year about 12,000 to 27,000 people die in this manner. Out of that, organs were procured from only about 2,500 in 1983. This means that we are currently retrieving organs from only about one out of eight potential donors.

Clearly there is much that can be done to procure organs for those whose lives are dependent upon these transplants. One survey conducted by the Gallup poll in 1983 showed that 72 percent of the public would be willing to be an organ donor upon death. One prominent organ procurement official has stated that it is his experience that four out of five families who have lost a loved one are willing to donate so that another person may be able to live, yet less than 5 percent of those who carry a driver's license have actually signed the donor's pledge.

Today I want to explore what has been done in Oklahoma and what can be done in Oklahoma to procure and transplant organs. I hope that we can use this opportunity to take a step back and look at where we are and where we need to go. Our mutual goal is for Oklahoma to be able to do its utmost to save as many lives as possible, not only in Oklahoma but throughout the country. We have a number of outstanding witnesses that we will hear from today.

We will break the panel up into different groups to try and facilitate everyone. Our first panel will be Kimberly Fuller, who is 8 years old, along with her parents Sandra and Dave Fuller from Elk City. We welcome you. Kimberly is now waiting for a heart and lung transplant. Is that correct?

Mrs. FULLER. We are trying to get on the list.

Senator NICKLES. You are still trying to get on the list?

We also have Keith Long from Marlow who is awaiting a kidney transplant.

I will stop there. Kimberly or Kimberly's parents, would you care to make any opening comments? Kimberly, I might tell you that, as I told you before, I have an 8-year-old girl, too. Her name just happens to be Kim and she is very cute, just like you are. Anyway, you can feel relaxed and you can tell us whatever you want. Are you feeling good?

Miss KIMBERLY FULLER. Yes.

Senator NICKLES. Good.

STATEMENT OF DAVE FULLER AND KIMBERLY FULLER OF ELK CITY, OK

Senator NICKLES. You are in the process of waiting to get on a list? Is that correct?

Mrs. FULLER. That's right. Kimberly's records have been sent to the University of Pittsburgh, and we are waiting now to see if they will consider her for further evaluation.

Senator NICKLES. Your doctors have informed you that you are in need of a heart-lung transplant?

Mrs. FULLER. That's right.

Senator NICKLES. Does that have to be approved by the University of Pittsburgh?

Mrs. FULLER. That's right.

Senator NICKLES. Has it been denied at Stanford?

Mrs. FULLER. Yes. We were turned down from Stanford in December 1982. They said Kimberly was too young and they wanted her to be at least 12 years old, because they said the cyclosporin might stunt her growth.

Senator NICKLES. But it is still your desire to take the gamble on stunting the growth so you can have the heart-lung transplant?

Mrs. FULLER. That's right.

Senator NICKLES. I would like to backtrack and give you a little of my history with Terri Lenz. I was traveling in western Oklahoma and was approached by some people living in Woodward, OK, who said, "We have a situation which we need some help on. We have an Oklahoman, Terri Lenz, who is 22 years old and has 3 children, ages 1, 2, and 3, who needs a heart-lung transplant and also needs some financial assistance." In other words, they said that

Stanford wouldn't put her on the list unless she had $250,000 or $300,000. The entire State of Oklahoma got behind her in an effort to facilitate. If Kimberly needs that type of assistance, then I would even say I am expectant that the State of Oklahoma likewise would respond in a generous manner to make sure that funds won't deny her the chance to receive the needed transplant.

So where do you stand right now? You're on the list. Has Kimberly been to Pittsburgh?

Mrs. FULLER. No.

Senator NICKLES. She has not? Is a trip to Pittsburgh scheduled for the near future?

Mrs. FULLER. We hope so. Our doctor called, Dr. Griffith, and explained Kimberly's situation and explained her age, and they indicated that they had never done a child this young; that they felt like they were ready to try. From what I understand, 19 is the youngest that they have done. He said that they would take a look at her situation, so her records were sent and her x rays have been sent, and that was a little over a week ago. When I talked to Dr. Griffith's secretary, she indicated they usually have an answer within a week, so we are expecting just any time to hear. Then, of course, we'll have to go on with more forms to fill out. We have talked to our insurance company, and so far they have said no, they will not pay for anything because it's exploratory. It's something that's an experimental procedure. We are just waiting to see.

Senator NICKLES. While waiting for the hospital to respond, we would appreciate it if you would keep us informed of the status of the situation.

You know, you talk about the youngest person being age 19. Well, this was done in 1981, and was the first successful heart-lung transplant. There was history made in this field and will be continually researched for the next several years.

Keith, could you tell us a little of your history?

STATEMENT OF KEITH LONG, MARLOW, OK

Mr. LONG. Certainly. I have been a kidney patient since August 1981. You mentioned in your opening comments that there have been particular advances made, particularly in the kidney field. To give you an indication of that, since I went on dialysis almost 3 years ago I have had two opportunities for transplants. Initially we thought that we would be able to get a kidney from my mother; we planned on that for the first year, and then about a month ago I was called up to the hospital in Oklahoma City with a possible cadaver kidney. In both instances the transplant was called off at the very last moment because they now have tests that indicate better whether or not a particular kidney will work with a particular patient. Of course, as you wait and wait and wait it becomes quite frustrating to be within 1 day or be within 30 minutes of going on the operating table and suddenly to be told that there is a little more waiting to do. Initially that's frustrating but when you have the time to sit down and reflect on it, the new technology which matches kidneys much better than even 3 or 4 years ago has saved me two operations to this point that would not have worked, most likely.

So in the nearly 3 years that I have been a kidney patient I have been on hemodialysis, in which you pump your blood through a machine and that machine filters the poisons out that the kidney no longer functions. In November of last year I went on CAPD, which is the newest and most revolutionary kind of dialysis, in that a machine is no longer required. They put a catheter into your stomach and you use a dialysate fluid, and you exchange that fluid four times a day, and it seems to be working quite well.

Shortly before I discovered why I was sick, I felt as though I got sick enough to drop out of graduate school at Oklahoma State University. I dropped out in March, and it was in August that we finally discovered that it was my kidneys that were malfunctioning. As long as I was on the machine, because there was not at that time a dialysis center in a college community in Oklahoma, I couldn't get back to college. But now, on CAPD, I feel as though I've got the increased mobility and certainly increased time—formerly I was spending 4 hours a day, 3 days a week on the machine, and those blocks of time are no longer lost—so since I have gone on CAPD and since it seems to be working well, I am planning to go back to graduate school in August.

Senator NICKLES. Good. What are the expenses in relation to the machine, and what is the procedure that you are following now?

Mr. LONG. Well, as I understand it, medicare of course picks up 80 percent of a kidney patient's dialysis costs, and I understand that they reimburse the dialysis institution the same for both hemodialysis and CAPD, although I understand that CAPD is a little bit less expensive in that trained staff are not required to be there with you minute by minute.

Senator NICKLES. Can most people that have a malfunctioning kidney take the CAPD, or do most of them have to stay on a kidney dialysis machine?

Mr. LONG. As I understand it, CAPD was originally formulated to help diabetic kidney patients because they do seem to have a more difficult time on the machine, because there is a stringent kidney diet when you are on the machine. You can only have so much protein, so much sodium, so much potassium, and coupled with the diabetic diet they were having a considerable problem with nutrition. But since CAPD has turned into such a good idea, apparently, they have opened it up to other people other than diabetics.

The requirements in this State—and I understand that the requirements vary from State to State, and I'm not sure it's a State requirement—but Midwest Dialysis where I am a patient requires first of all that the patient have good hand-eye coordination and dexterity, simply because there is a lot of meticulous work involved in exchanging the bags.

Senator NICKLES. How long have you been waiting for a kidney?

Mr. LONG. The day that they told me that my kidneys were malfunctioning, I was told that I was a good kidney transplant prospect. That was in August 1981, but we didn't go immediately onto the transplant list because we first wanted to explore the possibilities of a family donor. That was, the kidney transplant between my mother and I was scheduled for August, late August 1982—August

25, I believe—and it was called off on the 23d, and at that point I went on the list. I have been on for almost 2 years now.

Senator NICKLES. In Kimberly's case, how long have you known that she might need this type of an operation?

Mr. FULLER. About 3 or 4 years now.

Senator NICKLES. Has she been sick for quite some time?

Mr. FULLER. Since she was 2 years old.

Mrs. FULLER. She was first diagnosed when she was 2, and we were told then that her lungs were completely destroyed, and they didn't give her very long to live. She has since surpassed their expectations.

Senator NICKLES. Great.

Mrs. FULLER. Yes, so we're hoping.

Senator NICKLES. We certainly hope that she continues to surpass their expectations. That's fantastic. So this has been something that you have been living with and agonizing over for 5 or 6 years?

Mr. FULLER. Six years.

Senator NICKLES. Has her health improved?

Mrs. FULLER. She has continued to deteriorate, yes. She had chicken pox about 2 months ago, and that seems to have left quite a bit of scarring on her lungs, even more than she already had, which has made her even more short of breath and less able to do what she has done before.

Senator NICKLES. Kimberly, do you go to school?

Miss KIMBERLY FULLER. Sometimes.

Senator NICKLES. Sometimes? Are you in the first or second grade?

Miss KIMBERLY FULLER. Second.

Senator NICKLES. Good. Do you like school?

Miss KIMBERLY FULLER. Yes.

Senator NICKLES. Do you do well?

Miss KIMBERLY FULLER. Yes.

Senator NICKLES. Good. We want to thank Keith, Kimberly, and Kimberly's parents. We want to thank you very much for coming. You have helped, share with not only myself but the committee and those present, the dilemma that you're in. We will try to do everything that we can. I am appreciative of you for being willing to share your catastrophe and problem and challenge with the media. Thank you very much for coming.

Kimberly, thank you for coming, too.

Our next panel that we will have will be Kim Denton. She will be joined by Barbara and Bill Denton. Kim, we welcome you. This is the second time that I have had the pleasure of getting to say hi to you.

STATEMENT OF BILL DENTON AND KIM DENTON, CHOCTAW, OK, ACCOMPANIED BY: DR. GRETCHEN McCOY, PRESBYTERIAN HOSPITAL, OKLAHOMA CITY, OK

Senator NICKLES. Kim, How old are you?

Miss KIM DENTON. Fourteen today.

Senator NICKLES. Fourteen? Is today your birthday?

Miss KIM DENTON. Yes.

Senator NICKLES. Happy birthday to you? Congratulations. I heard a rumor that it was your birthday. That's very special. I also have a 14-year-old, but in this case it's a boy instead of a girl. You are awaiting a liver? How long have you known it?

Bill and Barbara, you can join in this at any time. You might step up a little closer to the microphone and pull it a little bit closer.

Dr. McCoy, would you like to join them? You are more than welcome to join them. We welcome you, Doctor, as well.

How long have you known that you were in need of a liver?

Mr. DENTON. We went to Pittsburgh in February. She was evaluated at that time and put on the list for an organ transplant, a liver, so we have known almost 4 months.

Senator NICKLES. In Kimberly Fuller's case, they said, "No, we're not sure that we can do this" because of the drugs or the age and size. In this case they told Kim Denton, "Yes, you need a liver and you're on the list" Now you're waiting for a liver and hoping and praying that one will come about in the not too distant future?

You went in February of this year?

Mr. DENTON. That's correct.

Senator NICKLES. So you have been waiting a few months. When did the problem first start? When did you find out that your liver was going to have to be replaced?

Mrs. DENTON. Kim has been treated for a condition called chronic active hepatitis since August 1981, and unfortunately she did not respond to medications which frequently will keep tabs on liver function and has shown signs of progressive deterioration of her liver. She has shown signs of imminent liver failure for about the last 9 months, 9 months to 12 months, and it was in December or January of this past year that we decided it was time to make arrangements for her evaluation.

Senator NICKLES. Then your family flew to Pittsburgh. You were told you were qualified and went through the procedures. They then determined what size or function that they felt like would be needed, and you are on a list. If you would have the transplant, it would be done in Pittsburgh. Is that correct?

Mrs. DENTON. Yes.

Senator NICKLES. You are standing by because the times are so short. How do they notify you that something may happen?

Mr. DENTON. Let me back up just a little bit. We drove to Pittsburgh.

Senator NICKLES. You drove to Pittsburgh?

Mr. DENTON. Yes. We didn't fly. That wasn't correct.

Yes, we are on the list. I have to say that if you look at a list, we have different classifications on the list. Terri Lenz, for example, was critical, so she was on one end of the list or the top of the list or whatever, awaiting an organ. Kimberly is more or less on the other end. The Lenz girl was critical. Kimberly is classified "convalescing comfortably at home," which I might want to argue with that now and then, but that's where she is classified, yes. We are on the pager system.

Senator NICKLES. Tell us about the pager. What do you mean by you are on the pager system?

Mr. DENTON. Well, if an organ comes available, they will first—on an organ that's compatible with Kimberly's requirements—they will first try to contact us by telephone. If there is no one at home to answer the phone, then they will call a phone number that is a radio station here in Oklahoma City which will activate the pager that we carry. At that point in time it will read out a phone number. If it's anything but a local call, we panic, but at that time we would call Pittsburgh.

Senator NICKLES. How much time is involved in a liver transplant? How much time do you have?

Mr. DENTON. Well, that's something else I need to say. Kimberly, to look at her you wouldn't know she is sick. In February we spent a good week at the hospital, met a lot of nice people. We met a lot of great medical people. I personally guess I never had been confronted with the reality that Kimberly was really, really, really sick until I was hit in the face with it up there. OK? I just thought that Dr. McCoy would pull her through and she's going to get better and it's just a little longer. Right? I appreciate you, Dr. McCoy.

But at the same time they gave me another—how do you say it?—"out"—an organ transplant. So we are waiting on an organ, but we saw a lot of kids who did not have the benefit or the luxury of the time, however little it may be, that Kimberly has. There are a lot of kids up there terminally ill, like the Lenz girl, so I personally just had my throat ripped out a few times. I get choked up rather easily anyway, but Kimberly is my oldest, so the rest of my kids are small. We saw a lot of small, very sick kids up there who, some of them, were living and had a good future due to the transplants.

Senator NICKLES. I don't want to get too personal, but I'm sure you have checked into the financial side of this question. Is a liver transplant, covered by your insurance?

Mr. DENTON. Well, when we got into it and we realized the expenses were astronomical—

Senator NICKLES. Could you give us an estimate?

Mr. DENTON. It could be anywhere from $50,000 to $100,000 or $200,000, depending on the complications. Some of the kids we met were waiting on their second organ because the first one was rejected or a blood clotting problem. There are numerous problems that can happen that would cause the need for another organ transplant.

I forgot your original question.

Senator NICKLES. Do you expect the insurance will cover it?

Mr. DENTON. OK. That was never really a question because they were calling it experimental, but whatever the insurance didn't cover then that was just a matter of dollars and cents. If I had to work the rest of my life or if Kimberly had to work the rest of her life, we would pay for it.

Senator NICKLES. Did that bother you?

Mr. DENTON. That didn't bother me, right.

Senator NICKLES. Having a 14-year-old and an 8-year-old and a couple of other kids as well, I can well imagine that would be the reaction of most people.

Kimberly, you're looking great. Are you feeling well? Do you have some times when you don't feel so well?

Miss KIM DENTON. Yes.

Senator NICKLES. Maybe you have an extra sparkle because it's your 14th birthday.

Doctor, have you found other cases like this in your experience in Oklahoma?

Dr. MCCOY. Fortunately, in my practice so far Kim is the only one that has required consideration of liver transplant at this point in time but yes, here in Oklahoma City itself we are seeing very many patients. I can think of about 15 in my own practice which at some point in time may be candidates for liver transplant, just depending on the rapidity of their liver decompensations.

Senator NICKLES. Can the liver deteriorate but continue to function, even just a portion of it functions?

Dr. MCCOY. Right. Fortunately, the Lord put us together with many organs that we have an amazing reserve. In the case of the liver, really we don't see biochemical signs of deterioration or functional signs of deterioration until we are decreased to about 10 percent of normal function, so there is a considerable reserve.

Senator NICKLES. Well, that is great.

I want to commend you again. Barbara, thank you for coming. Kimberly, we certainly wish you well and Godspeed. Hopefully your prayers will be answered in the very near future. Also, I wish you happy birthday. Thank you for coming.

Our final two panelists will be David Parker and his parents, Ralph and Sharon Parker. Also Mary Mitchell is with us today.

David and Mrs. and Mrs. Parker, we welcome you. Mary Mitchell, we welcome you as well. We appreciate your appearance before the committee today.

STATEMENT OF RALPH PARKER AND DAVID PARKER, OKLAHOMA CITY, OK

Senator NICKLES. David, I will start with you. You are 15 years old?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. Where is your home?

Mr. DAVID PARKER. Oklahoma City.

Senator NICKLES. Oklahoma City? Also a wrestler?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. Is that right? Good. You have had, a double cornea transplant?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. When did you have the transplant?

Mr. DAVID PARKER. The first one I had in November, right after Thanksgiving.

Senator NICKLES. November 1983?

Mr. DAVID PARKER. Yes, and the second one I had in February 1984.

Senator NICKLES. In February 1984?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. Has it worked well?

Mr. DAVID PARKER. It's doing great.

Senator NICKLES. Doing great? How was your vision before you had the transplant?

Mr. DAVID PARKER. Well, in my right eye I was legally blind. It was real bad.

Mrs. PARKER. He could see only light and movement in the right eye.

Senator NICKLES. You could just barely see a little light and movement out of your right eye?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. What about your left eye?

Mr. DAVID PARKER. It was a little better. I could distinguish what was going on.

Senator NICKLES. When you had cornea transplants, were they done in Oklahoma City at this hospital?

Mrs. PARKER. No, they were done at Deaconess.

Senator NICKLES. At Deaconess? How can you see now?

Mr. DAVID PARKER. My first one, I had my right eye done first, I have 20-40, and in my left one I'm not sure.

Mr. RALPH PARKER. I think 20-50 is what he said the last time.

Mr. DAVID PARKER. It's 20-50, 20-60, something like that.

Senator NICKLES. So it has improved substantially?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. Is that like the difference of night and day, in being able to see?

Mr. DAVID PARKER. Just about.

Senator NICKLES. Are you in school now?

Mr. DAVID PARKER. We just got out yesterday.

Senator NICKLES. Are you upset about that?

[Laughter.]

Senator NICKLES. Not too, right? I wanted to make sure that you were still going. Well, that's great, but you were in school after the operation?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. So you didn't lose a year?

Mr. DAVID PARKER. No, sir.

Mrs. PARKER. The most school he lost was with the left eye, and that was a week of school, 5 days.

Senator NICKLES. Is that right? Fantastic. Well, we are pleased to see that it was successful.

How long did you wait or have to wait for the transplant?

Mr. DAVID PARKER. Well, the first one I was on the list for 2 to 3 weeks. On the second one it was 4 days.

Senator NICKLES. Four days? That's fantastic. After the doctor told you that you needed to have another one, you said, "Fine,". Then only 4 days later, they wheeled you in and said, "Let's go to work."

Mr. DAVID PARKER. It was surprising.

Senator NICKLES. But you were pleased?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. You were eagerly anticipating it, especially after you had a successful first operation? Are you pleased that you had both?

Mr. DAVID PARKER. Yes, sir.

Senator NICKLES. Good. Well, I am pleased with that success.

STATEMENT OF MARY MITCHELL, MUSTANG, OK

Senator NICKLES. Mary Mitchell, where is your home?

Mrs. MITCHELL. My home is in Mustang.

Senator NICKLES. In Mustang?

Mrs. MITCHELL. Right.

Senator NICKLES. You had a tragedy in your family. Would you care to share that with us?

Mrs. MITCHELL. Well, my husband died with a heart attack in January 1983, and quite frankly we had never really discussed too much about donating organs and that sort thing, but I believe the little girl needed a liver transplant and her father went before a medical convention. This was the fall before he died, and I remember sitting there watching TV and him saying he just couldn't understand anybody who had somebody that died not being willing to donate organs.

He was a disabled veteran but it was nothing life threatening, nothing we expected. This was sudden. He was air-evacuated into Oklahoma Memorial Hospital and my oldest son is administrative aide to Governor Nigh, and of course is aware of the donor problem here. He got to the hospital because he was closer sooner than I did. He was there waiting with the chaplain when I got there, and while they had practially given up hope of reviving my husband they were still working with him. Shortly after, they came in and told us that he was gone, that they couldn't do any more.

My son said, "Mom, did you want to donate the organs?" Well, I was in shock. Of course, you can imagine. I wouldn't have thought of it. I mean, it just wouldn't have occurred to me but, since he mentioned it I said, "Oh, sure. Your dad would have wanted that." Then they came back later and told us that they could take nothing but the cornea because he was on medications and so forth, and the type of illnesses he had otherwise.

Anyway, we were notified then, I guess about a week later, that one of the corneas had gone to a man who had been blind for 33 years, and he could see almost immediately or very shortly thereafter. When you have experienced a death like this, you almost can't see any good of it. He was 55, you know. We still have a 15-and-a-half-year-old daughter, and it has really meant a lot to us. It has been just the one bright spot in the whole thing.

I wish that there were some way that something could be mentioned to people in emergency rooms by the chaplain or someone, just a little something to jog them, because if it had been left up to me—and he didn't have his billfold card because he wasn't a donor anyhow—I am a donor, it has been on my license for years, but being disabled he was not out that much and just never signed a donor card. But several months later when the numbness wore off, that would have been something I would have regretted not doing had somebody not just mentioned it to me.

Senator NICKLES. If somebody hadn't mentioned it to you, you probably wouldn't have thought of it?

Mrs. MITCHELL. I wouldn't have thought of it at all at that time. I think most deaths where they can donate organs probably are rather sudden. You know, the relatives are numb and probably in shock and they just don't think of it. Even if you have held long

discussions—and we had not, you know—and he had specifically said, "I want you to donate my organs," and I am sure that if we had ever discussed it he would have said that—

Senator NICKLES. Sure.

Mrs. MITCHELL [continuing]. But even if we had done that, I doubt at that time that I would have had the presence of mind to say, "Wait a minute," you know. If my son hadn't said anything about it, it would not have been done and there would be a man who probably wouldn't be seeing yet, or possibly wouldn't.

Senator NICKLES. Did you talk to the recipient?

Mrs. MITCHELL. Oh, no. No, I have never been told his name. That's fine.

Senator NICKLES. That's fine.

Mrs. MITCHELL. It's just enough that a part of my husband is still living.

Senator NICKLES. I think you are to be commended, and I appreciate your coming. I would echo exactly what you have said. I think that there are thousands of people in similar circumstances that, if confronted with the option, would make that decision. Some would not, and certainly they have that right.

Mrs. MITCHELL. Right. If they no or indicate they don't, then leave them alone, for I would never urge anybody to.

Senator NICKLES. Sure.

Mrs. MITCHELL. One other thing that has come up that really kind of amazed me, so many people have said to me, "Well, you couldn't have a funeral, then, could you?" This is the misconception that I think many people have. Now we had an autopsy, so all the organs had been removed, his cornea had been removed, but we had a funeral with an open casket and I daresay that there was anybody there who hadn't been told, who knew that any of the organs had been donated.

Senator NICKLES. Well, I appreciate your saying that because there probably are a lot of misconceptions. Also, I think a very valid point that you made is that a lot of people, had they thought of it, would be more than willing to donate organs. As a result they can save many lives. Some are youngsters and some are giving sight to somebody that hasn't seen in 30 years. The gift of sight for somebody that's 15 years old or somebody that's in their 40's or 50's is a very, very precious gift and one that you couldn't place a value on. It's something that all of us with good vision have taken for granted. On the same note, how many times have we thought very much about our livers or our kidneys. One doesn't think about his body organs until something goes wrong.

I wish to compliment you Mrs. Mitchell, for your appearance today. David, thank you for coming as well. I think it is important to show that there are some success stories. I think this involves two success stories because lives have been helped and benefited greatly by the generosity of other people. You are certainly to be commended and I appreciate your appearance before the committee today. Thank you very much.

Our next panel will consist of Dr. Samara, who coordinates the Oklahoma Memorial kidney transplant program; Dr. Robert King, who coordinates St. Anthony's kidney transplant program; and Dr. T.R. Medlock, who coordinates Hillcrest Hospital's kidney trans-

plant program. Doctors, we welcome you and we appreciate your appearance before the committee. You are, the three most prominent individuals that are working in transplants today in Oklahoma, particularly in kidney transplants. I will just open it up and let any of you make any opening comments that you wish to make. Dr. Samara, would you care to be first?

STATEMENT OF DR. SCOTT SAMARA, CHIEF, RENAL TRANSPLANT SURGERY, OKLAHOMA MEMORIAL HOSPITAL, AND DIRECTOR, OKLAHOMA ORGAN RETRIEVAL SYSTEM

Dr. SAMARA. Thank you, Senator.

I believe that overall, in the realm of kidney transplantation which is what the three of us deal with, the State has made progress in regards to trying to identify those patients who would benefit from a kidney transplant. In other words, every patient with end-stage renal disease is not a candidate for renal transplantation, and I think one of our jobs as kidney transplant surgeons or nephrologists is to try to identify that group of patients that are best served by a kidney transplant and thus offer that to them.

A lot of our efforts at the University of Oklahoma Health Sciences Center have been to try to identify those folks, those patients that would be appropriate candidates, and get them so listed on our kidney waiting list if they so desire to be placed on it after visiting with us. I think in the area of organ donation, a lot of positive strides have been made in the State, and I think that this has been on both a local level and a State level. We have had some help from the political arm. As you know, Governor Nigh pushed through the driver's license organ donor bill and he proclaimed January 1984 as organ donor month in the State of Oklahoma. That gave us a lot of public awareness.

Now the other side of the coin is professional awareness, and that's something that we all try to do but that's something that takes a lot of time, but I think overall—and we will get into specifics later—I think that the State has made some progress in developing an organ donor program.

Senator NICKLES. Thank you for your comments.

Dr. Medlock?

STATEMENT OF DR. T. RICHARD MEDLOCK, INTERNAL MEDICINE, HILLCREST MEDICAL CENTER, TULSA, OK

Dr. MEDLOCK. I feel like I'm outnumbered from the Tulsa area. I've got two Oklahoma City people here on both sides. I do appreciate the opportunity to come down.

Senator NICKLES. Well, we welcome you and appreciate the fact that Hillcrest would let you go and join us for a day.

Dr. MEDLOCK. First of all, I would like to express our appreciation, Senator, for your efforts in bringing this to the attention of the public and also to try to solve some of these problems because, on behalf of our patients, this is obviously a way to solve the problems, is to increase public awareness. There is a great deal of work that has already been done, as you well know, in the past. I think at least some brief comments, as Dr. Samara has already made, would be appropriate.

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For example, the Lion's Club several years ago was very instrumental in helping not only with the obtaining of corneas but also with kidney transplants early on, and I think they were a driving force behind the driver's license ability to donate an organ. The Kidney Foundation has been working, as you know, a great deal and continues to do so, to increase the awareness of all of us as to the need. The legislature has been very supportive. There is now legislation that recognizes the concept of brain death, which was one of the major stumbling blocks, of course, to organ donation. They have stepped in and been of great benefit. The media throughout has been tremendous. Whenever we have asked for help, they have always been there to do that.

I think the question then is, why is all this knowledge so important? I was able to be in the early stages of renal transplantation, at which time we would talk to a family about the possibility of donation and most often we would be refused. This was partly because of our own reluctance and because it was a new area and we were uncomfortable with it, but primarily because the families had not had time prior to this terrible event of one of their loved ones in the family having brain death—an automobile accident or whatever—and going through the strain of that, and then coming in to talk to them about donating a kidney. It was uncomfortable for us to put them through any more strain than they were already under.

Then, as Mrs. Mitchell mentioned earlier in one of the panels, I think that it became very obvious as we learned about this that it was something good that could come out of the circumstances and that someone could benefit, so we were not hurting the family we were asking to donate a kidney but it really gave them something positive to come away with as helping someone out. What we have found, as all of these groups have helped educate the public and we have learned ourselves, then as we approach families now it is unusual that they are not willing to donate, and I say that until we get into some of the newer forms of transplantation where I think we are back into some of the problems again.

To give you an example, in regard to Terri Lenz, we were all aware of her need for a heart-lung transplant. We had a possible donor in the Tulsa area and, as we looked into this in more detail we found out that to be a heart-lung transplant, that the donor would have to be transported away from Tulsa. If you can imagine one of the members of your family already being involved in a very difficult situation and then being asked to transport that donor to another city on the west coast or east coast to have the heart-lung transplant done there and then returned, obviously this is a very difficult thing to do and something that we all have to think about ahead of time and decide ahead of time that that's what we want to do.

Again, we appreciate the opportunity to bring this awareness to all of us and try to determine the best way we can at this point to get more knowledge and more understanding to all of us, including the physicians.

Senator NICKLES. Thank you very much.

Dr. King?

STATEMENT OF DR. ROBERT KING, NEPHROLOGIST, ST. ANTHONY HOSPITAL, OKLAHOMA CITY, OK

Dr. KING. I also would like to express my thanks to you, Senator, for your interest and willingness to come help with what has been a longstanding problem for a lot of people.

I would like to reiterate a couple of things that Scott said, and that is, education has to be our largest objective. Right now 80 percent of potential donors are either never approached or the family fails to give consent because of the way in which they are approached. Regardless of what else we do, unless we overcome that educational objective, we really will never have the organs that we need for the people who need them.

To put the need for organs in a little bit of perspective, in the United States now we get about 5,000 kidney transplants per year for a population of about 10,000 people who need those. The Center for Disease Control not too long ago completed a study in which they predict that within 3 years the United States alone will be doing around 10,000 heart transplants per year. There is going to be a tremendous demand for available organs, and it is going to require a really tremendous effort to supply that need.

We also need to educate especially physicians but also the public to the fact that this is a very successful form of therapy now. Still a lot of people have the idea that this is something experimental, that it's a last-ditch effort when you do an organ transplant, and in a lot of cases that's not really true. The success rate of even heart transplants now is high enough to consider it a very reasonable therapeutic alternative for a large number of patients.

Senator NICKLES. The success rate for kidneys is what?

Dr. KING. The national average now, about 80 percent.

Senator NICKLES. Eighty percent?

Dr. KING. Taking all types of transplants together, 80 to 85 percent.

Senator NICKLES. Dr. Samara, how large is the list of people that are waiting for kidneys in Oklahoma?

Dr. SAMARA. The State of Oklahoma, the three of us have our three lists, and I think if we added our lists up it's going to be right around 150 people. We have somewhere near 60 people on our list, and I think Tulsa is similar and probably St. Anthony's is right in the same area, so at any time there are probably between 150 and 200 people in the State who are awaiting a renal transplant. As Dr. King said, on a national level it's staggering. There are over 10,000 people who are awaiting a kidney transplant.

The more successful we are in doing transplants, of course, the larger that list grows, because certain groups of patients that we did not transplant a few years ago, we now do transplant, such as diabetics. Five years ago we would not do a kidney transplant on a diabetic. Today most of our lists will have at least 25 to 30 percent made up of diabetics because we can better manage the patient, we can now better handle the patient, so now people with diabetes and end-stage renal disease can get a kidney transplant. As we become more successful in the procedure, more and more people are going to become available to that, so the list will actually continue to grow in that manner.

Senator NICKLES. How many people had a kidney transplant in Oklahoma last year? Do you have those figures?

Dr. SAMARA. In 1983 I believe there were 55 transplants in the State of Oklahoma.

Senator NICKLES. Is that in each of the hospitals or all three of the hospitals?

Dr. SAMARA. That's the total.

Senator NICKLES. Are you able to match types and sizes to determine whether the body will accept the organ? Do you coordinate amongst each other for potential recipients and donors?

Dr. SAMARA. Well, our philosophy, the three of us all have the same philosophy. I say that and there might be some disagreement. Basically, on the computer list you have your patient, you have their blood group, you have whether or not this is their first or second or third transplant. You have the percent reactivity that their blood is. In other words, if they have had a transplant they might react against 90 percent of the kidneys you get a chance to get. You have their tissue typing, what type of kidney they might accept.

All that is on a computer network but we all by phone will not ask personally, but our coordinators who work with each other by phone, of course, when a kidney is available and we know what type it is, we'll look at our own list, of course, and if it doesn't match then we will call St. Anthony or they will call us, or we will call Tulsa or vice versa, and we will see if we can use that kidney within the State.

Senator NICKLES. How much time do you have with a kidney.

Dr. SAMARA. Once it's removed?

Senator NICKLES. Yes.

Dr. SAMARA. The latest that I have gone is 50 hours after it has been removed, and I think that any time it gets over 36 hours we start getting kind of antsy, but the method we're using now, up to 50 hours I think that we would all use that, but the sooner the better. Of course, if it is used within the State it is going to be sooner because the transportation problem is going to be less.

Senator NICKLES. This panel represents the large hospitals in Oklahoma City and Tulsa. Do you have donors coming from some of the outlying hospitals? I am thinking of western Oklahoma, some of the more rural areas of the State. Are we picking up any kidneys or other organs from some of the smaller hospitals in the outlying areas?

Dr. SAMARA. Occasionally we do.

Senator NICKLES. But not on a very substantial basis?

Dr. SAMARA. Not on a large basis, and in part that's just a matter of volume, because you figure that the average hospital will have one death per patient bed per year, and 3 percent of those deaths are going to be acceptable donors, so if you're talking about a 50-bed hospital you're really talking about an isolated number of potential donors in that situation.

Dr. KING. I think the other point is that these patients in the small, outlying communities are frequently referred in to the larger medical centers when they have this kind of brain traume, where they have available a neurosurgeon, a neurologist, and so forth.

Dr. SAMARA. Let me say that we have interacted with St. Mary's Hospital in Enid on two occasions for organ donation. We have mediflighted in from Lawton one donor but, as Dr. Medlock says, that's fairly difficult to do because of the family situation, because the body has to be removed.

Now what we have tried to do in our group is to perceive what areas might have substantial numbers of organ donors, and anytime a hospital has less than 100 inhospital deaths per year it's not economically feasible to spend your time going to that hospital to try to educate them in organ donation. Now when you add intensive care units and a busy emergency room, that of course increases the number of potential donors, so once you get out of the metropolitan area you're really looking at Enid, Clinton, Lawton, and those are about the only areas we have looked at and we have had some interaction with them but not a great amount, except from Enid we have had two donors.

Senator NICKLES. My staff tells me that 64 percent of the kidneys would be coming from outlying hospitals and 36 percent would be coming from the same facilities. Why is this?

Dr. SAMARA. By outlying hospital——

Senator NICKLES. They may well mean another hospital——

Dr. SAMARA [continuing]. Another hospital in a metropolitan area.

Senator NICKLES. I looked at the number of kidneys—I don't know what the terminology should be—my staff shows "harvested" and that seems like a harsh term——

Dr. SAMARA. We don't like to use that word, Senator.

Senator NICKLES. What would be the proper terminology?

Dr. SAMARA. Procured.

Senator NICKLES. Procured? That sounds a little better. They showed that Kansas procured 178 kidneys last year and Oklahoma only procured 60 kidneys. Are we doing as good a job or as aggressive a job as we possibly can compared to other States? Is there room for some improvement, a way to do a better job in Oklahoma through education and through forums like this or others?

Dr. MEDLOCK. Let me speak to that, if I could. I am not sure exactly what the situation as far as patients waiting in Kansas is, and so forth. Actually we are doing pretty well in Oklahoma; at least, I can speak for the Tulsa area and the cooperation has been tremendous. Obviously we are in a free enterprise system and hospitals compete, and yet when it came to setting up a transplant program, we had a tissue-typing laboratory in Tulsa at St. Francis; we had surgeons from St. John's and Hillcrest; and all the hospitals participating in organ procurement coming together in a single program which I think is a very positive sort of thing. As a result over the last 3 years in Tulsa we have obtained 66 kidneys. We have only transplanted, in the same time, approximately 28 kidneys.

Senator NICKLES. Repeat that. In Tulsa, you have procured how many?

Dr. MEDLOCK. Sixty-six kidneys, and we——

Senator NICKLES. In what year?

Dr. MEDLOCK. This was a 3-year period.

Senator NICKLES. Oh, 3? I'm sorry.

Dr. MEDLOCK. A 3-year period, and then we have transplanted in that same time 28, which means that the families have donated over 38 more kidneys than have been needed actually at this point in the Tulsa area. Now one of the problems, the reason we didn't use all of them—we have approximately 63 people waiting on the cadaver list for a transplant—but because of the tissue typing that we have talked about earlier, we have to wait on certain types of kidneys. Therefore, if we don't have the same sort of match that want, we have to send the kidneys out, so we are sending out more kidneys—and I think this speaks highly of the people in Oklahoma because they are kind about these sort of things and donating—but theoretically, if the rest of the country were doing as well as we are, then there would be enough matches somewhere else coming in that we would be able to transplant a much larger group of patients. I think we are doing well in Oklahoma. I think we need to do better and I think we can do better. The numbers you have already expressed earlier indicate that obviously there are potential donors there that we are missing.

One of my concerns, I think, about some of the recent legislation that is being proposed, is that it continue to be done through the private sector as it seems to be at this point. I really think this is the most appropriate way to do it. I think we should use the current facilities that we all have and improve them.

For example, I think that one of the things that we are looking at very carefully now that will be of significant benefit—and this came not from my interest but from other people within the hospital environment—we have set up a committee within one of the hospitals in Tulsa which will include neurologists, neurosurgeons, social workers, and ICU nurses, to explore how we can better obtain organs in these environments. Basically, the neurologist/neurosurgeon is going to see virtually all of these patients, and we know they are mostly going to be in the ICU setting. The chaplains are involved in this very deeply with the families. How can we best use this sort of approach within each individual hospital with that hospital personnel developing a program to improve the already good situation? I think this is preferable to setting up more bureaucratic processes or more organizations sort of outside that environment in some ways, and I think it's more cost effective in the long run.

Senator NICKLES. I certainly agree with that. As you noted in your comments, the legislation does provide for existing organizations and their assistance. We have an advisory committee that makes recommendations but we are trying to do it through the private sector approach and not a new bureaucracy. There is also legislation that would set up a whole new Federal system.

You mentioned that you are trying to encourage hospitals. Is that primarily in the Tulsa area, the neurosurgeons, or——

Dr. MEDLOCK. Exactly. Well, again, we work primarily in the Tulsa area and Drs. King and Samara obviously are doing these sorts of things in Oklahoma City, but this is our approach. We feel that using each individual hospital's personnel, that we are more effective at getting this sort of thing resolved.

Senator NICKLES. Mrs. Mitchell had mentioned that she probably wouldn't have offered her husband's eyes for donation if it hadn't

been brought to her attention. Are hospital personnel making those suggestions now on a more frequent basis throughout the State?

Dr. MEDLOCK. This is the purpose of this group, to approach the family and so forth. It's basically, in our experience in Tulsa at the present time, it has been somewhat left up to the fact that we continually within the transplant team notify the neurologists, neurosurgeons, and ICU nurses on a regular basis, send out information and so forth to remind them on a regular basis of the need. However, this approach is, I think, somewhat more personal in that someone—again, separate totally from either environment, that is, the person that would be obtaining the kidney for their patient or the person taking care of the patient who is donating—will be contacting the family under the direction of the primary physician, and so forth, and I think it may be a more effective approach than the one we use today.

Senator NICKLES. Then I compliment and encourage you because, again, as you pointed out there are probably thousands of people that would be willing to make that decision if confronted with it. However, their minds are not in that vein, and one of the purposes of this hearing is, to encourage a more general acceptance of it. Thus, if approached, they would be willing to give their approval, and it wouldn't be such a monumental decision to make.

And, too, the other purpose would be to get more people to make that decision on their driver's license or on a donation card now. We would hope that that would be the case.

Doctors, we appreciate your coming.

Dr. MEDLOCK. I need to make a comment on one other effort that we have done because I believe the public needs to be aware of this and I would like for you to be aware of this. In 1982, as we began to research this, we realized that in Oklahoma City there was really no coordinated effort in trying to organize the organ retrieval effort, so beginning in early 1982 we began putting together the Oklahoma organ retrieval system. The Oklahoma organ retrieval system—this is our donor manual—was funded through the State of Oklahoma teaching hospitals at the end of 1982. It has been fully staffed since July 1983. This fiscal year, which is July of 1983 until May 1, 1984, we have retrieved 40 kidneys as compared to 32 the year before when we were partially funded, and that compares to less than 20 the year prior to that.

Now this organ donor manual is present in all the affiliated hospitals' emergency rooms, intensive care units. It is used as a guideline for the personnel, and on the very first page it says, about the Oklahoma organ retrieval system, it says, "The Oklahoma organ retrieval system is composed of affiliated hospitals who are dedicated to the concept of providing cadaver organs for transplantation," so that is our basic, underlying goal. This tells who is a potential donor, how do you support that patient, who do you call, and we have it streamlined so that if one number is called, which is 271-GIFT, from one of the affiliated hospitals, that is all that has to be done. We have people on call 24 hours a day who will go and will manage that patient if they so desire, once he has been pronounced dead, will work with the attending physician, and depending on who wants to get permission we will get permission or try to get

permission, or work with the chaplain or the ICU nurse. One of our statements in here says, along with what has been said earlier, when it is talking about donation and the timing—because the timing is very critical when you ask the family—" It can be helpful to keep in mind that as medical professionals, we have an obligation to the family to make them aware of the option of organ donation." That is what we work under, that we feel that we have to at least make them aware that this is available. We routinely would go over to the intensive care units, the ICU units, and the emergency room units that are in service in the affiliated hospitals, so that at least the personnel there are aware of who is a potential donor, so that if they have a potential donor in their intensive care unit they can say, "Dr. John Doe, this would be a possible donor." At least then it makes the attending physician aware, and then we try to make it easy for the attending physician so that he doesn't have to do a lot of work to make that potential donor a real donor. Of course, it is under the guidelines of all the various hospitals that are affiliated, but this is something that we have done to try to help the donor cause, and I believe our numbers support that we are making some progress.

Senator NICKLES. Just one moment, Dr. Medlock.

According to my staff, the retrieval rate of independent organ retrieval agencies is much higher than hospital agencies. The independent organ retrieval agencies supply about 62 percent of the kidneys in the Nation, where hospital organizations supply the balance, about 38 percent. Any comment on that?

Dr. MEDLOCK. Do you know the difference in the two systems? I mean, an independent agency is a freestanding agency that basically is not associated with a hospital; it is not hospital based. Of course, one of the largest independent organ procurement agencies is the Southeastern Organ Procurement Foundation, so they are going to have a huge number of kidneys, although if we were hospital-based and we were affiliated with them, our kidneys would go in as being part of an IOPA—and independent procurement agency—rather than a hospital-based agency, so I think that some of those figures might be fallacious in that regard.

Senator NICKLES. But if you were a member of that, would that help you as far as tying into more organ donors?

Dr. MEDLOCK. We are in the process of joining that organization. I don't think so, because we have access to the procuring of organs, anyway. The one thing we think it may help in joining them is that for patients that are highly sensitized—that is, have trouble getting a good match—the sera can be centralized in one area so that a large number of patients can be cross-matched, as we call it, to see if their kidneys match. These people that have a hard time getting a kidney, I think that is the main benefit of that rather than increasing the number of organs.

Senator NICKLES. Did you have additional comment?

Dr. MEDLOCK. Yes. I know that time is a problem, and I just want to take one minute to appeal to you for some support with this new drug that I know you have heard about already, cyclosporin, and trying to get this funded. This is a relatively expensive drug, as you well know, but we feel that it is indeed an improvement, certainly

in certain circumstances, for preventing rejection in renal transplantation specifically as well as the others.

Senator NICKLES. And right now it is not reimbursed under medicare and medicaid?

Dr. MEDLOCK. Correct, and very few patients really can afford the medication at the present time. We really think that the data that has been presented shows that it is cost effective because, if it prevents rejection, it allows patients to get off dialysis. I would like to make the point that there is no question in my mind that the best treatment for renal failure is transplantation, the most cost-effective. Rehabilitation rates and everything are far superior. But this drug in one controlled study where it was compared with other medications that we are currently using showed that over a period of 3 years there were 15 less hospital days for patients on this medication as compared—this was a good study by a very large group.

Senator NICKLES. So you are going to save on hospital days, and transplants of kidneys as compared to the dialysis machines will usually pay for themselves within what? A year?

Dr. MEDLOCK. That's correct, and so we believe that it's not only better medicine but we believe it's cost effective to have this available through some mechanism.

Senator NICKLES. I think we are looking at making that reimbursable, and I expect that you will see that as part of the legislation.

Gentlemen, our panelists, thank you very much. Dr. King, I appreciate your invitation to visit St. Anthony. If we conclude this hearing on time I will look forward to having that pleasure.

The concluding part of the medical panel, if you would please come up, is Mr. J.D. Waters, Mr. Stanley Rockson, Dr. Jim Rowsey, and Harry Neer.

Dr. Rowsey, we appreciate your coming.

Is there room for everyone? Being the administrator, you should be able to have a seat.

Mr. NEER. I was going to say that perhaps I should remain on the outside.

Senator NICKLES. Dr. Rowsey?

STATEMENT OF DR. J. JAMES ROWSEY, OPHTHALMOLOGIST, DEAN A. McGEE INSTITUTE

Dr. ROWSEY. Thank you for letting me present some of the eye-banking needs in Oklahoma and the United States. I have outlined several areas where I think legislative assistance may be useful in organ transplantation.

I would like to begin by stating that corneal transplants are the most successful of all organ donations and, because of the expertise in this area, they are no longer experimental but are generally considered reasonable and recommended by most insurance carriers for many blinding corneal diseases.

There are two areas that I would like to emphasize today where legislative assistance could be invaluable to us. The first is in education of the public. At this time we have three main methods by which we educate the public about the needs for organ donation.

The first is the driver's license bureau donor cards in Oklahoma. Newspapers and television, such as your presentation today, is also valuable to allow individuals in Oklahoma to see the patients' needs. The third is private organizations, such as the Lion's Clubs, and private mailings to heads of households to find the needs of the patients in the State. I believe this provides educated support for subsequent legislation.

The legislation that I would like to recommend is as follows: No. 1, I would recommend to the State legislators and to the national legislators a greater consideration for the Uniform Donor Act, to provide accident and autopsy tissue to representative local tissue banks. It is my opinion that the medical examiners are the most auspicious officials to direct and coordinate this type of tissue acquisition. In Oklahoma, that relationship has been a model of coordinated effort from Dr. Jordan and the medical examiner's office from our new legislation which allows us access to many traumatic cases which would otherwise have been lost. That has taken effect this year and is greatly appreciated, and has increased the Lion's Club acquisition of donor tissues as far as corneas are concerned.

It is also appropriate to consider how the legislators may allow the medical examiners access to that tissue. Our current legislation allows them to request of the family the possible donation of donor tissue which would otherwise be lost.

The second area that I would like to emphasize is that personnel recruitment and training requirements should provide the most compassionate and articulate technicians in this field to the nurses, physicians, and families. Mary Mitchell's caveats are well reviewed: that is, the representatives of tissue banks should be versed in the grieving needs of families during this very intense time of bereavement at the time of death of a loved one. Shock at that time makes us forget. Our family members may have told us that they would like to donate something, and everyone forgets at the time of sudden death. Tissue procurement ultimately resides with the personal initiative of these technicians, invaluable people, often at inconvenient hours, however. There is no substitute for dedication and enthusiasm for technicians in the donor process at 2:30 in the morning when everyone else is sound asleep. Having those types of individuals who are enthusiastic and dedicated to the process of donor tissue and will speak to the families at that time is most important.

Last, the technicians should have access to tissue requirements, as discussed previously, in renal transplantation and all subspecialties of medicine. Computer compilation of cross-indexed data with monthly reports to all participating physicians, both in corneas and in livers and in kidney transplantation, so that all of the participating physicians are aware of the needs of the other patients in the other subspecialties, would ensure maximum distribution.

I thank you for letting me present these remarks.

Senator NICKLES. Thank you, Dr. Rowsey. We appreciate your comments.

Dr. Rockson?

STATEMENT OF DR. STANLEY ROCKSON, CARDIOLOGIST, PRESBYTERIAN HOSPITAL, OKLAHOMA CITY, OK

Dr. ROCKSON. Thank you.

As you have noted on the program, I am a cardiologist and I will address my comments to the needs for cardiac transplantation as they affect Oklahoma.

As you know, we don't have a heart transplant program that is active in Oklahoma, although this may be forthcoming in Oklahoma City in the next few years. However, there are a reasonable number of Oklahomans who are potential candidates for heart transplantation, and we probably see up to three to five a year who suffer from heart diseases that would ideally be treated by heart transplantation.

The problems in cardiac transplantation as far as organ procurement are the same as for kidney or liver or any of the other organ systems we have talked about. I feel that the most compelling issue at this point relates to the funding of programs for cardiac transplantation, and what I would like to do is share an anecdotal case, the most recent one that has come to my attention, to highlight the problems as I see them.

In my care is a 28-year-old woman who is suffering from paripartal cardiomyopathy, which is form of heart failure which is a very rare complication of a normal pregnancy. This woman delivered a child in November of 1982 and subsequently went into heart failure; was not ultimately responsive to medical forms of treatment and was therefore a candidate for heart transplantation, in that she is likely to die of this condition within the next 12 to 24 months without it.

She was denied funding, of course, by her private insurance carrier. She was approved for Federal and State medical assistance, both of which in essence also refused to give her much in the way of assistance with the ultimate goal of heart transplantation. She had been initially accepted as a considered patient in the University of Minnesota transplant program and ultimately had to turn down that slot because of unavailability of funding.

The problem I believe in thinking of cardiac transplantation as an experimental modality is that from the medical/scientific literature, I think it has exceeded that designation. The mortality rate of cardiomyopathy, which is a disease of the heart muscle which produces heart failure in 2 years, is essentially 100 percent when it reaches the terminal stage. That is, there are no survivors beyond 2 years once the designation of terminal cardiomyopathy has been made. With heart transplantation, it has now been shown that the survival rate can be as high as 60 percent in 4 years. That places the procedure not far behind coronary artery bypass grafting as a very reasonable surgical modality to treat a medical disease and, therefore, I would think reconsideration about funding for such a procedure, even though it's obviously very, very costly, there is no alternative for the affected patients other than a surgical approach.

Senator NICKLES. You initially had one patient. Is this applicable to a lot of people in Oklahoma?

Dr. ROCKSON. I would say that we're talking about small numbers of patients but we have patients to whom the consideration is vital, I would say, in the State of Oklahoma. There might be, under a liberal set of criteria, perhaps 5 to 10 people a year in that category.

Senator NICKLES. Thank you.

Mr. Waters?

STATEMENT OF J.D. WATERS, PROCUREMENT COORDINATOR, RENAL TRANSPLANT PROGRAM, OKLAHOMA MEMORIAL HOSPITAL

Mr. WATERS. Thank you.

I will speak a little bit about the role of the coordinator, and they are all different. Coordinators generally try to assist the transplant programs in various aspects.

Senator NICKLES. You are presently the coordinator?

Mr. WATERS. No. I am one of two coordinators in the university system right now. Judy Schwartz is my cohort there. There are coordinators at St. Anthony's and at Hillcrest in Tulsa.

I did speak with the coordinators at St. Anthony's and at Hillcrest before coming, just to have their input so that I would not be a single representative here, but as I said, all the coordinators have different job descriptions and different roles in fulfilling the individual needs of their transplant programs. My particular area of interest is in the organ donation process itself, not in the clinical transplant aspects of it. Consequently, Judy and I have been able to work very nicely together because she is a nurse and does have good working clinical knowledge.

The coordinators in the other programs, again, have some other responsibilities to the clinical aspect of it that I don't share. My interest in organ donation has led me to try to retrieve as many transplantable organs as possible every time we have a donor. Even though I am in the kidney program—I work for Dr. Samara—he has been more than lenient and supportive in helping generate other transplantable tissues for the waiting population.

I am new to Oklahoma, coming here in July, and in the short time we have been here we have been able to get family permission—not necessarily organ donation—for 8 livers, 11 hearts, and 5 heart-lungs and 38 kidneys, so we do have a good, broad-based program. I left off the corneas. There is a gentleman down here on the end, I need to cover his specialty. I left off the corneas because we have gotten cornea permission in all of the cases where we have gotten renal permission. However, because of some medical criteria—use of respirator, length of time, et cetera—we have not had as many corneal donations as I would like.

Senator NICKLES. Was that just out of Oklahoma Memorial?

Mr. WATERS. That is in this, yes, sir. I feel naturally I would like to get more organs, and I think I can say that for all of the coordinators and all of the physicians in the transplant programs. The consensus of the majority of the coordinators that spoke with us was that we have more public and professional education. I think there is a need for some real strides. Here you never see a billboard. You see very few bumper stickers, and I have yet to see a

sign on the back of a taxicab. In these areas we could stand some assistance, making the public more aware.

The professionals we need to make more aware through professional education programs.

I think that in Oklahoma we have a very good potential, in that at least the numbers that I come in contact with, and counting the organs that we have brought in from out of State or other transplant programs, that accounts for 34 cases that I have been involved in, 32 of those were neurosurgical cases and I have found the neurosurgeons in Oklahoma so far to be the most supportive, most cooperative group of neurosurgeons that I have ever interacted with. I think Oklahoma has the right formula to really take off and have more donors in their system.

Senator NICKLES. Good. That's part of what we're here for. So thank you very much.

Now our next panelist is Harry Neer, who is the administrator for Presbyterian Hospital. Again, I wish to thank you and your staff for the accommodations and hospitality that you have shown this committee today.

STATEMENT OF HARRY NEER, PRESIDENT, PRESBYTERIAN HOSPITAL, OKLAHOMA CITY, OK

Mr. NEER. I want to start by making the comment that we are pleased to have the opportunity to host the hearing today.

I hope that I might focus in on cost and charges, since Dr. Rockson alluded to at least one specific case, that might help us look at what we can expect in the future. I heard of this family, and believe that every family that has an illness of this type, regardless of Blue Cross, are going to find ways to secure the funds for the loved one, and yet you are looking at dollars and costs and charges which in their case could be $50,000 up to $200,000, and there are institutions at the same time—hospitals in particular and probably physicians as well—having a token number of dollars to spend, and I will take just a few moments to talk about that.

Cost reimbursement under medicare enabled hospitals to put investments in new programs and services and spread that profit into programs that didn't necessarily make a profit or break even. In addition to that, we had private insurance where we were able to overcharge—and I say overcharge—for the services through the private carriers on ancillary services to subsidize programs and services that couldn't pay for themselves.

Since October of this year for some of us, and I think even more extensive in the future—Blue Cross has recently moved to a DRG rate as well—is we are going to a price based on diagnosis, which means that those institutions who previously were able to cost-shift, slowly but surely hospitals are going to be in the position of no longer cost shifting. What I see in the future in transplantation, in many programs of the $100,000, $200,000, $300,000, is that there is not going to be any means to finance it other than from the private person or from philanthropy.

It is very popular at this point, and understandably when it's a young person or a disabled person that has a heart transplant, that people are going to want to give from their pocket, and it's under-

standable that donations are going to be much easier at the levels on which we are talking. It was in the kidney program, although it's not quite as easy today to raise money even for people that are having kidney transplantations. I see a crisis coming down the road, a crisis that some hospitals are meeting already. Some of the big proprietary chains have already made policy decisions that 4 percent is the max for bad debts, charity, the poor, or anyone else that comes in the door, which then shifts to not-for-profits where there are education and other costs that are involved that are going to be on a fixed-price basis. Very complex unless you understand most of the way we are financed, but I can say reasonably that hospitals and institutions across this country, unless they are compensated some way to pay for the costs, we are going to see a major crisis in transplantation, not maybe this year but at least in the next 2 to 3 years. That one that needs to really be addressed is the catastrophic issues of the $200,000 family, and there are disease entities that fit into that category. The Robin Hood principle of taking from the rich and paying for the poor is a thing of the past, and it certainly will be past in the future.

What is unfortunate is that the "poor" is going to be the middle American as well when we get into the catastrophic cost, not the person that does not have the money, who has no money, no assets—although they are going to be in trouble in the next few years because we're not going to see teaching institutions being able to afford to take care of those who don't pay their bills—but at the same time the Federal Government as well as the local governments are cutting back on medicaid, cutting back on medicare, because of the tremendous high costs. I don't argue that we have a serious financing problem with medicare and with medicaid in the States, but what is going to be left over is these very, very important programs are going to decide, where in the past they did not, that we cannot finance. That will hurt.

Two other comments, and this is not to be derogatory toward the Federal Government but I would like to reiterate some comments that were made previously about private enterprise and the private system. I have not experienced, in my 20 years in hospital business, that where the Federal Government has become involved, that the bureaucratic systems and the dollars spent have many times exceeded the benefits that have been given into the health care field.

Medicare looked like a tremendous benefit to hospitals and to physicians throughout the country in 1966. I don't believe that one hospital nor one physician will look at it the same way today, that it is the same benefit as it was in 1966. As a matter of fact, I don't think that the subscribers, the medicare patients, necessarily see the issue of medicare benefiting them today in the same way they did then. This whole issue of quality of life, this whole issue of how institutions are going to finance that care, is a catastrophic problem that has to be addressed now, looking into the future.

With respect to organ retrieval, I still believe it would be best to be at the local level, and that it should be controlled by the medical community and the physicians that are involved. We need to have that organizational structure, and with the Federal Government, if funds are going to be coming in, fine, but not the bureaucratic systems to figure out some way to distribute organs. I am

also opposed to people making money extensively off of organs. I think it's a crime, some of the charges that people are being forced to pay for a kidney or a heart, and I think it's a shame to benefit from the kinds of dollars that people are benefiting from in some sectors of the country, and I don't believe that is right, but I think free enterprise can and in fact will take actions toward that.

Basically those are the two areas. I am not going to give an education on hospital costs or physician reimbursement but I really believe that, as we look through the problem of transplantation, though few at this point, we must recognize that it has to be financed and that the financing packages today that are dwindling, we will not have money today to pay for those programs unless they pay for themselves, and that is not supposition. That is going to be the reality of 1985. It will get worse in 1986 and it will be nonexistent in 1987, if we continue the direction we are going.

Thank you.

Senator NICKLES. Thank you very much, Mr. Neer.

Dr. Rowsey, a couple of comments: You have been active with the Dean McGee Eye Institute for some time?

Dr. ROWSEY. Yes.

Senator NICKLES. We have had some success stories, for example, David Parker, and his successful double cornea transplant. Do we have enough donors to take care of the demand, in this area?

Dr. ROWSEY. No; we do not. We normally transplant around 350 corneas in Oklahoma a year. I believe there are approximately 30,000 corneal transplants a year in the United States. We are about 109 corneas shy at this time of those individuals who require corneas. Obviously our priorities are for babies under a month of age who require a corneal transplant, in that either they see before they are 3 months of age or they never see at all, so those priorities are structured, as previously described, for those individuals with the greatest needs. We are very greatly delayed in some of the patients who are bilaterally blind, even in Oklahoma where we have a reasonably good procurement program to obtain sufficient tissue. Both—pain and blindness are the two major disasters that face someone with corneal disease; those are both alleviated with a corneal transplant.

Senator NICKLES. So the need is still there, and you still need a lot more people to make a donation?

Dr. ROWSEY. Yes.

Senator NICKLES. I appreciate that, and I am also very proud of the fine work that we have being done in Oklahoma. I think you and the McGee Eye Institute are really to be complimented for the outstanding work that you have done.

Dr. ROWSEY. Thank you.

Senator NICKLES. Dr. Rockson, you mentioned several things. You talked about having a patient who needed a transplant and the difficulties that patient would have in financing such an operation. I am assuming from your comments, in fact, that it would not be reimbursed. Was that correct?

Dr. ROCKSON. Yes, that's correct. She was unable to tap enough private resources to make it feasible for her to even contemplate going to Minneapolis for evaluation.

Senator NICKLES. They would not put her on the list unless she could come up with a certain amount of money?

Dr. ROCKSON. That is the general trend. Now in Minnesota they have been working with Federal financing institutions as well as private funding, and they are quite flexible, from my recent experience, compared to some of the other more rigid programs like Stanford, but in most cases there needs to be some kind of an assurance that the financial matters will be taken care of.

Senator NICKLES. I personally got involved in the Terri Lenz case because she needed some money, and was not sure whether or not Government assistance would be available. I had heard from the outset that it would not and time was of the essence, so it was necessary to proceed full steam in the private sector. There was some thought, though, if we had had more time, that some States would have made reimbursements.

Dr. ROCKSON. That's correct.

Senator NICKLES. And that it might be possible, if Oklahoma and the administrators in Oklahoma would work with HSS, that there might be some type of reimbursement package that would apply toward heart transplants and possibly heart-lungs as well. Is that correct?

Dr. ROCKSON. Well, we explored this issue specifically with the Oklahoma State institutions and learned that yes, they would theoretically be willing to make some sort of a financial adjustment for the patient if the work was done in the State of Oklahoma, and the availability of a transplant program is nonexistent, so it's kind of a double-bind situation. If what was going to be done in Minneapolis could be done in Oklahoma City, they would help this patient.

Senator NICKLES. Is it the case that the Federal Government will usually match on medicaid?

Dr. ROCKSON. Right.

Senator NICKLES. You mentioned also that such financial adjustments are nonexistent in Oklahoma because we don't have a heart transplant facility at any of the hospitals. Does it look like that might change in the next few years?

Dr. ROCKSON. It's my understanding that a couple of the institutions in Oklahoma City are interested in starting heart transplantation. I do know that our cardiovascular surgeons at Presbyterian Hospital are also interested. It requires a great deal of liaison with the basic science support, immunology, all of the issues that deal with the posttransplant care of the patient, but I think it's something that could be developed in Oklahoma City and in the State of Oklahoma.

Senator NICKLES. Wasn't Dr. Bernard in Oklahoma 1 week or 2 weeks ago?

Dr. ROCKSON. Yes.

Senator NICKLES. Was that discussed when he was visiting the city?

Dr. ROCKSON. I don't know if that was under discussion or not.

Senator NICKLES. But it might be possible in a few years at Presbyterian or one of the other institutions?

Dr. ROCKSON. Very much so. For cardiac transplantation the surgery is technically easy. The postsurgical care is, in essence, analogous to kidney transplantation, as is organ procurement, so a lot of

the substrate is already there and if the interest exists and the funding exists, then it could become a reality.

Senator NICKLES. Do we have kidney transplants now in Oklahoma?

Dr. ROCKSON. Yes.

Senator NICKLES. In both Oklahoma City and Tulsa?

Dr. ROCKSON. Yes.

Senator NICKLES. Is that correct? I said kidney. What about liver?

Dr. ROCKSON. Not liver.

Senator NICKLES. No liver. I was mistaken. We have kidneys done in three of the hospitals, represented by the previous doctors, but no livers——

Dr. ROCKSON. No hearts and no lungs.

Senator NICKLES. No lungs?

Mr. NEER. I might make a comment about the reimbursement by the Department of Human Services. Right now, for approved patients under the Medicaid Program in the State, hospitals are being paid less than their cost.

Senator NICKLES. For what?

Mr. NEER. For any patients that come into the hospital that are being treated, that are covered under one of the categorical programs, under the Medicaid Program, the cost is higher than what is being reimbursed on an average daily rate by the Department of Human Services. Recently some hospitals got significant reductions in the amount of money toward the care of those patients.

How we have handled that in the past is, we have passed that on to the third party payers, and so I don't believe the answer is for the Department of Human Services—and I know there are problems in numbers of dollars—to shift those dollars to a few cases such as heart. We have an overall financing problem. Granted, the person that is waiting for a heart transplant, it is very visible and it is understandable, it is life and death. But there are other patients, too, that it is life and death if they don't receive treatment and there is no way to fund it. That's what I was referring to earlier, is that hospitals in the future are going to have difficulty when they don't get paid the amount that covers the cost of that service to provide that service.

The problem there, I think it was Baptist Medical Center that was announcing their open heart program, and it was Bernard, and they may have a way of funding that at this stage but I can see the problem for all hospitals, including Baptist, including ourselves, as to how we're going to fund this when it's constant shrinkage of the number of dollars for the care that we are already providing. So one of the things that could be done is, under the medicaid program, is discontinue taking care of those patients entirely. I guess what I am suggesting is that hospitals around the country are in fact considering that because of this issue, so we have a greater crisis that is on our hands. In the meantime we have people like the lady that he is referring to, that will die because there is no way to finance it and the fact that there is not a program, but just having a program in Oklahoma will not solve the funding problem. It will just increase the cost problem in the State of Oklahoma, and the only thing I can see that they could do, unless they increase

taxes and funding to their health program to cover what already exists, is to shift dollars that they are now paying to some of the other categorical programs to cover that one heart case.

Senator NICKLES. Gentlemen, we appreciate all your statements. You have shown that we have some very difficult dilemmas, both as hospital administrators and as public servants. You mentioned the medicare program earlier. It started in 1965 as a zero cost program and I think last year it was $59 billion and compounding at a 15 percent annual rate. As a matter of fact, the deficits that are projected for medicare in the out years—due to the transfer of money from the medicare fund to the Social Security fund the last couple of years—although discontinued now, helped deplete those funds. We expect those to be paid back but still expect to have a deficit position in medicare somewhere in the timeframe of 1989 to 1991. It concerns a lot of us, especially if you look at the demographics. People are living longer because of the progress that has been made in the medical profession, and that certainly will increase the demand on those services and the cost of the services, so we have some real challenges. We will appreciate working with the members on this panel and others that we have had today as we seek some solutions to those challenges.

One final question: Mr. Waters, you have been one of the coordinators in Oklahoma for how long?

Mr. WATERS. Since July.

Senator NICKLES. Since July? You came from where?

Mr. WATERS. I came from the east coast.

Senator NICKLES. From the east coast?

Mr. WATERS. Yes, sir.

Senator NICKLES. Were you in organ transplants?

Mr. WATERS. Yes, sir. I started out in Dallas and spent about 9 years there, and I went to the east coast for a year and then back to the Midwest.

Senator NICKLES. So you have worked with some other States in trying to coordinate their organ transplant programs?

Mr. WATERS. Yes, sir.

Senator NICKLES. How does Oklahoma compare to some of the other States in your opinion? Are we about average? Could we do a lot better?

Mr. WATERS. Well, I would definitely like to do better. I tend to get in trouble if I'm not very active, and I like the activity. [Laughter.]

Senator NICKLES. That can happen to a lot of us.

Mr. WATERS. I really feel like that, yes, we could do better here, not necessarily on the number that are being transplanted, although we do have an active waiting list and I think we have a fairly active transplant program. There are a few people, naturally, that we could transplant—we couldn't transplant the entire list this month, in other words. If we had, I believe Dr. Samara said, 160 roughly waiting, if we got 160 kidneys we couldn't transplant 160 people this month, but we could do better in that category and we could do better in the organ sharing and distribution of these kidneys to other programs.

Senator NICKLES. Thank you for your comments.

One final comment for the panel and Mr. Neer, you mentioned in part of your statement that you didn't think it was right for individuals to charge for or sell their organs. I might mention that there have been some reports of individuals that have donated with a price tag, some exorbitant prices. In other words, yes, you can receive this organ but only if you can write a very large check. Part of this legislation would prohibit that. We would basically just make it public policy that you would not be allowed to sell organs. I agree with your comments and I am confident that that also will be part of the final legislation that is passed. It is also in the House bill that is starting to move now, so we will take care of that problem and you won't see those type of headlines. I am not saying that it is totally prohibited, but I think we should at least make it against the law and make a penalty to discourage those that attempt it.

To our panelists, thank you very much for your contribution. You have been a very good asset to this hearing. Thank you.

Our next and our final panel, we have Jean Radney representing the Oklahoma Lions' Bank; John Holroyd, who is the president-elect of the Oklahoma Kidney Foundation; Dick Pereles, director of communications with Kerr-McGee, and Bob Linn and George Hicks, representing the Oklahoma City Board of Realtors.

Jean, would you care to be first?

STATEMENT OF JEAN RADNEY, EXECUTIVE DIRECTOR, LIONS' EYE BANK, ACCOMPANIED BY DR. WILLIAM MUENZLER, MEDICAL DIRECTOR, LIONS' EYE BANK

Ms. RADNEY. Yes, I would like that very much.

One of the exciting things about my job is that I see results like Dave Parker here, and then also get to have the opportunity to meet with the people out in the——

Senator NICKLES. I want to make sure that everybody understands that you are working with the Lions' Eye Bank.

Ms. RADNEY. Right. I have been working for the eye bank for 10 years.

Senator NICKLES. Great.

Ms. RADNEY. It is a real rewarding job in that we help people to see again. When I get a call like I did the other day and this little kid said, "How long am I going to have to wait?" then that makes my job a little bit harder. I think in Oklahoma we are doing a fairly good job in the cornea area. We have up to 6 hours to remove eyes.

Senator NICKLES. Six hours?

Ms. RADNEY. Yes, sir. At present we need about 109 corneas.

Senator NICKLES. Is that in the State?

Ms. RADNEY. In the State of Oklahoma, right.

Senator NICKLES. We need 109?

Ms. RADNEY. Right. We have a good system throughout the State of Oklahoma, with field directors and physicians helping us remove eyes and the Highway Patrol helping us, and Presbyterian Hospital receives all our eyes for us here and then we pick them up.

I feel like on of the things that we can improve on is education in hospital personnel. As Mrs. Mitchell mentioned, I think it is

real, real important if someone would just say, if a victim should die in the emergency room, "Is this an organ donor?" All that would be necessary would be to answer no, and if the answer is yes then the hospital personnel will say they'll take care of it, and they will call the proper organization, the kidney people or the eye bank, and we will take care of it. I think that the private sector, as far as the eye bank is concerned, is real good here in Oklahoma.

Senator NICKLES. Good. Well, I compliment you for your efforts. I think we have all seen the little white canes in the drives that the Oklahoma Lions have made. You have been working with the eye bank for 10 years—do you have an estimate on how many people have received eye transplants?

Ms. RADNEY. The eye bank is 25 years old and we have done about 400 transplants and, as Dr. Rowsey said, there is a good percentage of success.

Senator NICKLES. The success rate, if I remember correctly, was 85 to 95, 80 to 90?

Ms. RADNEY. 80 to 90 percent.

Senator NICKLES. That's very high.

Ms. RADNEY. Very high.

Senator NICKLES. That's great. Thank you very much.

Mr. Holroyd.

STATEMENT OF JOHN HOLROYD, PRESIDENT-ELECT, OKLAHOMA KIDNEY FOUNDATION

Mr. HOLROYD. I am with the National Kidney Foundation of Oklahoma, and I might just start by telling you a little about the work we have been doing here in Oklahoma.

First of all, the Kidney Foundation is supporting by providing funding to help support research into new drugs which may help to prevent rejection, and we are also providing funding for aggressive research into the transplant rejection phenomenon and trying to better understand this phenomenon.

What we are doing for the patients is that we are expanding our drug bank program, which aims at providing statewide service of drugs at cost available to people who are on hemodialysis. It would appear that a worthwhile addition to this may be to extend that to people who have recently undergone transplant surgery, to assist in the provision of cyclosporin.

One of the other things we are aiming to do is to provide public education. Many of our fundraising drives are so that we can buy literature which can be distributed mostly to the general public, and in addition to this we maintain an active speakers bureau so that if any community or school organization needs a speaker to inform them about kidney disease, we would be able to supply someone.

We have actively pursued the distribution of kidney donor cards, up to and including Governor George Nigh. Our office in Oklahoma City acts as an information clearinghouse. We have a hot line telephone. People call in. We try and put them in contact with the correct agency, and on some occasions we are able to provide the help they seek directly.

There are some other things I wanted to cover. The question of the driving licenses and authorizing people to remove organs after death, I have a driving license and I have been involved in an organ donor program and I have signed a donor card, but my driving license doesn't reflect that because I was never given the option. I rather think it would be better if it was to go the other way: You have to actively oppose the removal of organs and you have to so state on your driving license, rather than to take the affirmative step of stating you would want to donate your organs. Also, I think that that should be made entirely the responsibility of the driver, not the clod who is filling out the driving license. I am sure that happens very often. They get busy and they just check the appropriate box, and away it goes.

I haven't got any other remarks to make. I think people have already made them, so I think I will probably delete my views at this point.

Senator NICKLES. If we have your statement, we will enter your statement and any of those statements of our panelists in the record in full, if you wish to summarize them.

Mr. HOLROYD. Thank you. At that point I would like to close.

Senator NICKLES. Thank you very much.

Mr. Pereles with Kerr-McGee.

STATEMENT OF RICHARD PERELES, DIRECTOR, CORPORATE COMMUNICATIONS, KERR-McGEE CORP.

Mr. PERELES. Thank you, Senator. I have a brief statement. It might be easier for me just to read that. It describes our involvement in this situation.

I would like to thank you for the concern you are showing Oklahomans and other Americans in this important effort.

Kerr-McGee has the privilege of participating in a program that involves us at a human level with which the public rarely identifies our industry. I speak of Oil Industry Lifesaving Flights, or, as the acronym describes it, OIL Flights.

OIL Flights was launched January 1 of this year, and essentially makes available aircraft to transport organs, doctors, recipients, or surgical teams in the United States on an emergency basis as a supplement to existing local or special services. The transplants are limited to heart, liver, pancreas, and bone marrow cases because these organs have such a short postextraction, useable life.

As of this date, 46 companies in oil and oil-related businesses have contributed cash and made available a pool of 51 planes in 18 cities and 11 States. Corporate aircraft are used whenever possible, but cash is used to charter flights when corporate aircraft are not available or when specialized life-support systems are required. Incidentally, of the 46 participating companies, 9 of those are based in Oklahoma.

In practice, an OIL Flight is initiated by a transplant surgeon or a transplant coordinator who contacts the OIL Flights division of the Greater Houston Hospital Council Research and Education Foundation. The foundation analyzes the needs of the case from both a geographic and medical equipment standpoint, and matches those needs against the available pool of participating corporate

aircraft. The company most strategically located is then notified and asked to employ its pilots and planes.

On March 25, Kerr-McGee had the honor of making the first use of a corporate aircraft in the OIL Flights program. In this case a Kerr-McGee plane left Oklahoma City early in the morning, flew to Minneapolis and picked up a team of transplant surgeons, proceeded to Pensacola to remove an organ from a donor, returned the team and organ to Minneapolis that afternoon, and returned to Oklahoma City that evening. It was a long, grueling day for the pilots but one which could not have been spent on a more worthy or satisfying pursuit.

We at Kerr-McGee are representative of the energy industry and of people everywhere. Diseases and illnessses that create the need for organ transplants affect us all equally. Technology has proved that organ transplants can be performed, and with the combined commitment of involved employees and the use of our corporate aircraft on the mercy missions of OIL Flights, we can help.

We are all aware of the escalation of medical costs during recent years for even common health problems. The costs of transplant surgery are, of necessity, many times greater. By being the transportation link in the complex and critical organ transplant chain, programs such as OIL Flights are helping to make it possible for patients who need organs to have them when costs alone might otherwise preclude such lifesaving surgery.

I thank you.

Senator NICKLES. Thank you very much, Mr. Pereles. We appreciate the outstanding work that Kerr-McGee has done in this area, as well as the other companies. I think you are to be commended for that.

Our next panelists are representing the Oklahoma City Board of Realtors, Mr. Linn and Mr. Hicks.

STATEMENT OF BOB LINN, OKLAHOMA CITY BOARD OF REALTORS, ACCOMPANIED BY GEORGE HICKS

Mr. LINN. Thank you, sir. On behalf of the Oklahoma City Board of Realtors, I might mention the president of our board is sitting back in the back.

The involvement the Oklahoma City Metropolitan Board of Realtors has had as far as transplantation is concerned began in January of this year, and it was a public relations project on the local level of the Oklahoma City Board of Realtors that eventually became the State level and then regional level, as far as raising money for Terri Lenz. We started off actually ignorant—the committee did, I did—as to exactly what the ramifications were, what was involved, and so forth, except there were certain key ingredients, one of which was time being of the essence. We had to raise something like $175,000, or help raise that amount of money, within 10 to 12 days, so we knew immediately that we would either accomplish the goal or not. Once we were successful in helping the people around and across the State accomplish that, then we went on in the Midwest.

In the last few weeks Barbara Rickman, a member of our committee, has spent a lot of time getting information as far as what

other activities the Oklahoma City Board of Realtors can get involved with as far as transplantation is involved.

Senator NICKLES. Well, I think you are to be commended and, Mr. Linn, you are to be commended as well. Having been involved in trying to help raise some funds for Terri Lenz, I witnessed the Oklahoma City Board of Realtors take the lead and become instrumental in its eventual success. I remember on "Terri Lenz Day" that every realtor's office was open, collecting, soliciting, and quite successfully so.

Mr. LINN. You also had a press conference in Tulsa which you——

Senator NICKLES. That's true. We did have a press conference in Tulsa to ask people to help in that part of the State, because most of the attention had been focused in Oklahoma City and the western part of the State. You are really to be commended for doing that and for all the organizations that are represented on this panel. You have reached out and you have taken the bull by the horns and have been aggressive in trying to help solve the problem. I think in Terri Lenz you are seeing a successful conclusion to the problem. She is doing quite well. I have visited with her family on a couple of occasions, and they are very elated. She hasn't been able to get together with her three young children but, having young children, I can imagine what a fantastic reunion that will be.

Therefore, the Board of Realtors and the others are to be commended for the efforts that you have made, I am aware of how extensive yours as well as many others efforts were to make that a success. The media is to be congratulated as well for their fine coverage of it.

Mr. LINN. It was all over the media, of course, and without that we never would have been there. There were so many people that got involved in it, and it was a cause that worked and a goal that was met. It was fantastic, and thank God it was successful.

Senator NICKLES. Yours and many others efforts in this and the OIL Flights, make me really proud to be an Oklahoman. I have seen from the east coast some similar efforts, but I don't think that they have handled them with the energy and enthusiasm that we have shown with some of these Oklahoma cases.

Mr. Pereles, I will compliment yourself and your organization, Kerr-McGee. We are sitting adjacent, to the Kerr-McGee Eye Institute, which has done so much for so many people, and I am also aware of your company's involvement in the OIL Flights. I think you mentioned, that, there are 46 companies——

Mr. PERELES. Forty-six companies.

Senator NICKLES [continuing]. That have donated their pilots and their aircraft, basically on call at all times, and willing to ask not how much it is going to cost but where do you need us to go, and we'll do it. It was interesting to hear your story about picking up some doctors transplant team from Minneapolis.

Mr. PERELES. Minneapolis, yes. The logistics are such that there are vast distances to be traveled, and the pilots might get a call in the middle of the night and it's time to go.

Senator NICKLES. Well, it is life and death. These organs "lives" are very limited once detached so unless the mode of transporta-

tion and the logistics are worked out in a very quick and coordinated manner, it won't work. The result, of course, could be a death, and so it does make quite a difference. I am proud, too, of the fact that out of the 46 companies, we have 9 in Oklahoma; and of the founders in this group, several are Oklahomans Kerr-McGee and others have been most generous not just in their donations of planes but also in their financial assistance. There will be some very beneficial results and the demand will grow to expand this list all the way across the United States.

Mr. Holroyd, I haven't disagreed with anything that anybody has said today, but I think I probably would disagree with your statement of reversing the—I think it should be a voluntary donation and people should opt for it, whether it be on your driver's license or on your donor's card. We discussed this in our office. Some people have suggested that and some people would have—I have been very active in this legislation for some time now—and others have suggested, well, let's just make it nationwide that everybody would be a donor unless they opted out. I haven't gone that far or haven't agreed to go quite that far as of yet, but I have been hopeful that through hearings like this—we have had hearings in Washington DC—through organizations such as yours and through possibly some others—we have contemplated, in Oklahoma we have met with a lot of religious leaders asking them to maybe make it available at their churches at the conclusion of their services or something like that so people would think about it. I agree with you, yes, it is available on your driver's license and a lot of people don't think about it. You had some suggestions that might be helpful there as well, but certainly your organization and the work that they have done in donor cards, and I think you even—do you have a place where individuals can sign up?

Mr. HOLROYD. Oh, yes; we have an office here.

Senator NICKLES. Well, we appreciate that, and hopefully by some of this exposure and other means I can help in your efforts. I don't know if anybody would want a Senator's organs or not, but I have signed up. You are to be commended and certainly have our full cooperation in trying to encourage as many people as possible.

Have you found that maybe there has been some resistance? I think there was initially some resistance for people to donate blood, but then, after a certain period of time there was a greater level of acceptance in the community.

Mr. HOLROYD. My experience has been quite interesting. I found that it was less reluctance; it was more apathy. I went to point out that the miserable life that some kidney patients have, the only hope they have for getting off a kidney dialysis machine is either death or transplantation, and when they are faced with these rather brutal facts they start to rethink their position as far as an organ donation is concerned. We just need to spend a great deal more time educating the general public. There aren't enough of us to go around, so any help you can provide will be greatly appreciated and I am sure it will help to change the attitude of the public at large.

Senator NICKLES. I appreciate your saying that. I think you made some excellent observations and that, as Mrs. Mitchell said, we need to have more of the professionals give this option and quite

possibly more people would accept it. I am confident that they would.

We say thank you to all our panelists and the participants in the hearing. We are most grateful. You have concluded the hearing. These are all of our scheduled panelists. If there are additional people that have comments that they would like to make for the record, we will open that up. I also will be keeping the record open for a couple of weeks to supplement it, for other persons who have additional comments they wish to make.

Thank you, panelists.

Would you care to identify yourself for the record?

STATEMENT OF BARBARA SWINEFORD, LAVERNE, OK

Ms. SWINEFORD. My name is Barbara Swineford and I am from Laverne, OK. The reason I am here this afternoon is to express on behalf of the Williams family, whom I spoke to last evening—these are Terri's parents—the Williams' were invited to come to the hearing but because of Terri's condition they didn't feel like they could leave her. I think, as most of you know, that she had to go back into intensive care but she's out now and she's doing fine. I spoke to her last night. Her parents asked me to express their thanks, not only to you but to all of the people in Oklahoma, all of Oklahoma, who helped Terri to get to the point where she is today, and I am happy to do so. Thank you very much.

Senator NICKLES. Barbara, we appreciate your saying that and we're elated with the good news. I can tell you that, having been in western Oklahoma on a couple of occasions, I have been most impressed with the people of Laverne and the people of Woodward and all of western Oklahoma. You have gotten behind Terri Lenz like I have never seen before. I gave the commencement address at Panhandle State University last Sunday, on Mother's Day, and made the announcement that she was being operated on at the time I was giving the commencement address, and you could just tell the people were elated because they were holding their breath and their prayers were answered and they have been answered. The community has pulled together like few communities would, and you are to be commended for it.

STATEMENT OF BARBARA RICKMAN, WARR ACRES, OK

Ms. BARBARA RICKMAN. I am Barbara Rickman, and I am representing just John Q. Public here today. I first became involved in organ transplantation because of Terri Lynn and the Oklahoma City Metropolitan Board of Realtors, of whom I am a member, and I am also on the PR committee.

I would suggest that any organization that needs PR pick a person, a recipient, and go to work. The PR that you will see through the media more than pays for the efforts that you put forth, that you will put forth. I saw it pull our organization together and people who were very competitive —for real estate companies to real estate company—try to pull together in a unified effort.

Following the fundraising for Terri and the goals being met, I found a need to personally pursue organ transplantation and look into it. I, on my own, have spent several weeks or a couple of

months doing this now and helping two people in different States that have had successful programs. I feel our primary need is for education, both of the medical profession and of the public. I feel this can be done through the media, through slide presentations to organizations and schools, to remind the public of every phase of becoming an organ donor and of transplantation itself.

I would like to see the Government kept out of it as much as possible because we are going to have to turn to private enterprise for the financing of such programs. I honestly think that the doctors need to be educated in the smaller, outlying areas as to organ donations and procurements. This, I think, can be done through seminars and training films. Of course, I think that we need to have a task force within the State of Oklahoma made up of lay people and professionals to look into the actual projected costs, not just talk about it and say it's going to be a lot. Let's get some dollar and cents figures put down and really, really dig into it.

Another place where we are in great need, and I was just talking in the reception area to someone, is to be able to solicit that organ at the time when it could be obtained. The doctors, it is something people don't want to do. They don't want to go to that family at that time and say, "We would like to take your loved one's organs." I propose that a group made up of lay people be trained in the Oklahoma City area as a trial, to be on call 24 hours a day to remove these organs, if that would satisfy the physicians. There are also physicians who are very comfortable doing this but I do believe that there are some people who are compassionate, who have had the experience before, and possibly those people who had donated organs of family members would be able to relate and be able to talk to these people and increase the number of organs that we would be able to procure in the State of Oklahoma right now, and I believe on an experimental basis to pick one hospital or one community would be good.

I have read S. 2048 and I agree in context with most of it. There are some parts of it that I don't agree with. I think that the institution—and you might be able to enlighten me—of making a national registry of organ donors could be a paperwork nightmare, primarily because of the State laws. Right now, if a person isn't a card carrier they do not—the family may say they do not want the organs donated. I see no reason to do it that way. I think the money would be spent better educating the public to come forward at the time of need, to volunteer the usage of the organs.

Another factor is a paranoia about donating organs: If my name is on the list and somebody else is dying in the next room and needs my heart and I am the right type, am I going to get the medical care?" Well, having gotten into the study of transplantation, yes, by all means. In fact, you would probably get better care because if there is any chance that you are going to be a donor, they are going to want to keep you in peak condition. A lot of people ask this question, and I understand it, plus the fact if a national figure or a President were to be shot in the heart or in an organ and they went through this national registry and they picked and chose who they wanted as a donor that would match, I can see why paranoia would come up with the people unless there is education and expla-

nation as to what you're doing. That's why it has to be totally volunteer.

I can sympathize with the gentleman that was up here before. I know that Great Britain does have a law or is getting ready to enact a law where it is mandatory that you are an organ donor unless you say otherwise; that everybody is automatically but then they can squelch it. I believe that Oklahoma ought to start its own Oklahoma Transplant Foundation. I think it should be nonprofit and self supporting, coordinate a computer system within the State of Oklahoma, lobby for needed legislation, and provide financial aid for transplant recipients that do not have the financial aid at this point.

[The prepared statement of Ms. Rickman and additional material supplied for the record follows:]

BARBARA J. RICKMAN
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1. My initial involvement with organ transplantion in Oklahoma began with helping to raise funds for Terri Lenz.

As a committee member for the Oklahoma City Metropolitan Board of Realtors, it was part of my duties to find a public relations project which would "help the image" of the Board.

I candidly state that the positive PR received by the OKCMBOR's endeavors, far surpassed their expectations. The Board helped raise over $330,000.00 for Terri, and promoted public awareness to the plight of transplant recipients.

In return, the OKCMBOR received much more than they gave. The "free" PR from television, radio and newspaper coverage in recognition of the efforts of the Board, I am certain would have exceeded our annual budget for PR several times over.

The PR within our own organization was even greater. Companies that are normally competitive, almost to the point of paranoia, were drawn together in a unified cause to "Give Terri a Chance".

The OKCMBOR's job completed and goals met, I personally felt compelled to further investigate the status of organ transplantion in the state of Oklahoma. I have spoken with doctors, organ procurement co-ordinators, directors of foundations both locally and nationally. I have discussed the situation with Presidential Aide Michael Batten, staff members of the American Council on Transplantion and Thelma Theil, executive director of the American Liver Foundation, among others.

I have discussed at length, with directors of various donor

projects that have been successful in Texas, Flordia, and Nebraska.

I have toured kidney dialysis programs, spoken with kidney recipients and people across the state who are currently in need of an organ transplant.

2. My recommendations for strengthening the organ transplant system in Oklahoma I must address several categories.

*To motivate the public to donate organs and tissues for transplantation. -- The development and activation of a program designed to educate the public on the needs, benefits and process of organ donation. This can be accomplished primarily through media PSA's, newspaper articles, audio visual presentations for schools and organizations, and explanatory brochures addressing the common questions and answers relating to organ donation.

*To improve organ identification and refferral to organ procurement programs by health professionals. -- Education for medical professional using audio visuals, printed literature and seminars.--The active participation of these professional to solicit donor organs from family members. Currently, due to failure of the medical community to answer this need, hundreds of potential organs are being "lost".--A possible alternative to this problem is the training of lay people who are willing to discuss with family members (at time of eminent death of their loved one) the need for organ donation. A single group

of volunteer lay people could be utilized by all hospitals in a given community. -- The development of an intrastate computer system for organ recipients. This system needs to follow programming of those that are currently in use on a national level, and have the ability to tie directly with those systems currently in use. I would suggest that any Oklahoma hospital with over 100 beds have a computer terminal. Smaller hospitals should be urged to use the terminals of larger hospitals within a given geographic area.

*To promote the effective distribution and usage of multiple organs and tissues. -- By utilizing an intrastate computer system we could be more certain of meeting the needs for recipients first within the state and eliminate the possiblilty of transporting an organ out of our state which could benefit an Oklahoman. After determining that an organ cannot be utilized within the state, the organ should be directed to the "highest need" recipient that it can feasibly be used for, within the national computer network, taking into consideration necessary vialibility of transporting the organ.

*To maintain and coordiante such a program a foundation totally dedicated to the concept and development of organ transplantation.-- The Oklahoma Council on Transplantation is a dream that with the efforts of private citizens and industry could be a wonderful reality. I beleive that such a council should be established

on a private level with contributions from the private sector. It should not receive funding by government grants or agencies. This foundation would:

a) Be non-profit

b) Be self supporting

c) Enact all of the afore mentioned programs

d) Coordinate the computer system

e) Lobby for needed legislation

f) Provide financial aid for transplant recipients

3. The Federal Govern ment can help facilitate an efficient transplant network by continuing to enact legislation such as S. 2048.

In my opinion, the majority of the Organ Procurement Act of 1984 is pretty much on target. At this time I do question one part of this legislation. Sec. 399A Sub heading (B) "...a national registry of individuals who,..."

This could be a nightmare of compiling information, which, due to current state laws would render a registry useless, since next of kin has the final say over donation of organs. I feel that the monies necessary to maintain such a registry could be used better in educating the public to ACTIVELY volunteer their preference about organ donation on their own or their family members behalf. This would remove this responsibility from physicians or the registry, if it were established.

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Established in 1898 by Sisters of St. Francis

May 1984

Statement: Current Transplantable Organ Program Needs in the State of Oklahoma

Addressed to: Public Forum on Organ Transplantation headed by Senator Don Nickles

From: Brent Schafer, R.N., Charge Nurse, Transplant Department; St. Anthony Hospital, Oklahoma City, Oklahoma

The donation of various organs is a humane and honorable gesture yet clinical transplantation is still limited by the availability of suitable organ donors. In 1982 there were 65,765 Americans in the ESRD program. In 1982 there were only 5,358 transplants (cadaver and living related combined). It is speculated that by 1990 there will be 80,000 to 100,000 individuals enrolled in the ESRD program. These statistics reflect an increasing potential for kidney transplant which consequently demands a greater public awareness and response to the need for organ donation. The majority of transplant centers in the U. S. rely on cadaveric kidney donation for 75% of their total renal transplants. The state of renal transplant is at the point where 50% of the existing population on dialysis are suitable renal transplant candidates. The supply of transplantable organs is grossly inadequate to meet the needs of thousands of waiting Americans and hundreds of Oklahoma's potential recipients.

The profession community is just beginning to accept the responsibility of educating its members in the area of organ donation. Past success rates in transplantation and attitudes and concerns regarding brain death are no longer justifiable reasons for ignorance of the subject matter. The current success rate with renal transplants is approximately 70% at one year, increasing from 40-50% success rates in the middle and late 1970's.

Just as challenging is the experience of convincing the professional communities that brain death is a sound medical diagnosis supported by the medical and judicial communities. Once professionals accept this comfortably, organ donation can become a logical consideration when a

trauma victim is declared brain dead. The need for cadaver organs will continue to increase as the clinical outcome of organ transplantation improves. The rehabilitation that is experienced by the transplant recipient alerts the medical community to the increasing number of clients choosing transplantation as an option.

The shortage of organs is not because of the lack of potential donors but rather the lack of awareness on the part of the medical and public communities in general. Each year thousands of kidneys are lost in the emergency rooms, ICU's, CCU's and other intensive care units. Why? Primarily due to a lack of education in recognizing the potential donor or a lack of awareness of the need for organ donation. Another primary cause is the inability to approach the family of the potential donor due to a sadly insufficient training program in this aspect of organ retrieval. The aforementioned situations pertain to the need for education of professions in the field, both physicians and support personnel as well. Ideally, organ donation is something that every person should think about and decide upon prior to the usual traumatic situation which places the burden on the remaining loved ones. In the State of Oklahoma, according to the experience of this writer, an organ transplant billboard has never been viewed, a consistant newspaper media program on organ donation has yet to be presented, or published brochures placed in public areas expressing the need and method for organ donation for families has not been found. An available resource for community organizations, for the purpose of educating the general populace regarding organ donation, is obviously lacking.

An unaware and uneducated public and professional community will obviously be a fearful and hesitant resource for potential donors. Emerson stated "Fear springs from ignorance". Education is the key to overcoming ignorance and in overcoming ignorance the fear in organ donation cannot but decrease.

It is therefore the feeling and prime consideration of this institution that an intense professional and public education program be initiated for the purpose of increasing the awareness of need for organ donation, educating the professional in the major centers and community hospitals in recognition of the potential donor, working with community organizations, churches, civic groups, public service organizations, and the general public as target groups for educational programs for organ donation and preconsideration of donation. When preconsideration occurs there will be no more waiting lists to worry about and we can invest our energies into other important medical issues. This can only occur as a result of consistant, intensive, informative, and diversified educational

programs on the statewide level which originate in the transplant centers and branch out to the potential donor facilities throughout the state. This type endeavor takes time, money, and a dedication to a program for a positive advancement of an organ transplant network. Various facilities, with regard to transplant centers, can work in a hormonious and complimentary atmosphere which will advance the cause of the transplant programs, which is obviously a better quality of life for the organ recipient and a feeling of gratitude and peace for the donor family. In a society of financial unrest, an increasing population of potential recipients or dialysis-dependent patients furthers the burden incurred by the general population for medical financial support. If by transplantation this burden can be substantially decreased then every measure available should be entertained to augment the availablity of transplantable organs. All available resources to increase public and professional awareness of the need, the ease with which organs may be donated, and the immense satisfaction gained by organ donation, should be entertained.

Respectfully submitted,

Brent Schafer, RN, CS

Brent Schafer, R.N.
Charge Nurse, Transplant Department

Senator NICKLES. Thank you very much for your statement; as all of our panelists, we appreciate your comments.

We are going to do something that I have never done at the conclusion of a hearing, and this is the conclusion of our hearing. We have a special presentation, and that is to Kim Denton. It is her 14th birthday and so to congratulate her on her birthday, we have a birthday cake.

[Whereupon, at 3:28 p.m., the committee recessed, to reconvene at the call of the chair.]

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